



The Commonwealth of Massachusetts
Executive Office of Health and Human Services
Department of Public Health
Bureau of Health Professions Licensure
239 Causeway Street, Suite 500, Boston, MA 02114

CHARLES D. BAKER
Governor

KARYN E. POLITO
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MARYLOU SUDDERS
Secretary

MONICA BHAREL, MD, MPH
Commissioner

Request for Extension

Name:
License No.:
Docket No.:

Licensure Condition that is the subject of this request:	Date originally due
<input type="checkbox"/> Submission of proof of completion of continuing education on the topic(s): 1. 2. 3. (If more than 3 continuing education courses, please specify the topic and date due on a separate sheet of paper and submit with this form.) <input type="checkbox"/> Submission of proof of completion of continuing education for prior renewal cycles <input type="checkbox"/> Submission of CE course descriptions for pre-approval	1. 2. 3. 4.
Obtain employment that will qualify to fulfill the minimum period of supervised professional practice. <input type="checkbox"/> I am not currently practicing in my profession but I am actively seeking a job. <input type="checkbox"/> I am not currently practicing in my profession and I am currently unable to actively look for work. (Explain below) <input type="checkbox"/> I obtained qualified nursing employment after the Effective Date of Probation. I am requesting the extension to complete the minimum period of "active practice" for my Probationary Period.	N/A
<input type="checkbox"/> Successful completion of examination requirement: <input type="checkbox"/> Multistate Pharmacy Jurisprudence Exam <input type="checkbox"/> Massachusetts Dental Ethics and Jurisprudence Exam	
<input type="checkbox"/> Supervisor's submission of verification form or letter	
<input type="checkbox"/> Supervisor's submission of periodic report	

<input type="checkbox"/> Evaluation/report from: <input type="checkbox"/> Medical provider <input type="checkbox"/> Mental health provider	
<input type="checkbox"/> Submission of proof of compliance with plan of correction	
<input type="checkbox"/> Submission of updated policies and procedures	
<input type="checkbox"/> Submission of spore testing results	
<input type="checkbox"/> Proof of completion of reporting requirements: <input type="checkbox"/> Notify other jurisdictions of discipline <input type="checkbox"/> Medical Error Report (MER) to ISMP	
<input type="checkbox"/> Enrollment with DTMC for urine screens	

<input type="checkbox"/> Other:	
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(If more space needed, please write topic and date due on a separate sheet of paper and submit with this form.)

Please explain the reason(s) why you are requesting this extension:

Additional request(s) for extension *may be* allowed. However, such request(s) must be made prior to the expiration date of the previous extension granted.

I understand and agree that as a condition of granting this request, the Board may extend the minimum period during which my license is on a restricted status as necessary to accommodate the request.

Signature

Date

To submit this form for consideration, please send complete and signed forms to the attention of Karen Fishman by:

1. Email (must be a scanned copy with signature appearing on the form):

Karen.L.Fishman@MassMail.State.MA.US

2. Fax: (617) 973 – 0983

**3. Mail: Probation Monitor
 Bureau of Health Professions Licensure
 239 Causeway Street, 5th floor
 Boston, MA 02114**